Civilian Welfare Fund Council

Authorization For Blood Testing

Participant's Section: Please print the information requested in the spaces provided below prior to forwarding this form to your physician for his/her review and signature. Bring the completed Authorization with you on the date of your test.

This form with Physicians signature is REQUIRED in order to participate.

_____	_____
Participant's Name	Physician's Name
_____	_____
Address	Address
DOB:_____ Gender:_____	
_____/_____	_____
Telephone (Home) (Work)	Telephone

Physician's Section: Your Patient (listed above) is going to participate in the Picatinny Civilian Welfare Fund Council Blood Testing Program. In accordance with our policies a physician's authorization is required for participation. Your authorization will enable your patient to have any of the following tests performed: CBC, Lyme, PSA, Ferritin, and Thyroid, at little cost to him/her. You will receive a copy of the results for your review and any follow up you deem necessary. A copy is also provided to the patient for his/her information.

Please sign in the space provide below to authorize your patient's participation. To minimize expenditure of your time, we have requested that your patient provide your address and telephone number. Please take a moment to review the information for your accuracy.

Thank you for your anticipated cooperation. Please feel free to contact us with any questions or comments at
(973) 724-4016. Bridget Dollberg, Chairperson

_____ may attend Civilian Welfare Fund Council's Blood Testing Program as described above.

_____
Physician's LabCorp Client/Account number

_____	_____
Authorizing Physician's Signature/Date	Physician's License No.

CWFC BLOOD TEST REGISTRATION FORM

TEST DATE:	ACCESSION #:
NAME:	PHONE:
DOB :	Gender :Male ( ) Female ( )

Active Duty Military ( ) /Family Member: ( )	Retired Military ( ) / Family Member: ( )
Civilian ( ) / Family Member: ( )	Retired Civilian ( ) / Family Member: ( )
Contractor ( ) / Family Member : ( )	Other (please specify): ( )

PHYSICIAN'S NAME AND ADDRESS REQUIRED FOR TEST TO BE ADMINISTERED.

PHYSICIAN NAME:	
CITY:	**STATE:**

"HOLD HARMLESS" agreement must be signed by all participants:

I ________________________________, understand that the medical tests being taken at this "Blood Testing Program" are completely voluntary and are being conducted by a private organization known as "LabCorp". This organization is in no way connected with Picatinny, NJ or the United States Government. I, therefore agree to indemnify and hold harmless Picatinny, NJ and the U. S. Government from any and all costs, charges, claims, demands, or liabilities of any kind arising from participation in the "Blood Testing Program."

* *

TO BE FILLED IN BY CWC PERSONNEL ONLY:

_____ CBC CHEM PROFILE $ 20.00

_____ LYME $ 22.00

_____ PSA $ 13.00

_____ FERRITIN $ 12.00

_____ THYROID $ 10.00

TOTAL PAID:

Verification: